DEPARTMENT OF PUBLIC HEALTH
AND HUMAN SERVICES

CHAPTER 79

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Subchapter 1

General Provisions

37.79.101 CHILDREN'S HEALTH INSURANCE PLAN (CHIP)

(1) The rules in this subchapter implement the children's health insurance program, which is provided through the children's health insurance plan (CHIP). CHIP is jointly funded by the federal and state government. The purpose of CHIP is to provide health care benefits to uninsured individuals under the age of 19 years from low income families who are not eligible for the Montana medicaid program. (History: Sec. 53-4-1004 and 53-4-1009, MCA; IMP, Sec. 53-4-1003, 53-4-1004 and 53-4-1009, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04.)

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37.79.102 DEFINITIONS As used in this subchapter, unless expressly provided otherwise, the following definitions apply:

(1) "Advanced practice registered nurse (APRN)" means a registered professional nurse who has completed educational requirements related to the nurse's specific practice role, in addition to basic nursing education, as specified by the board of nursing pursuant to 37-8-202(5)(a), MCA.

(2) "Applicant" means an individual under the age of 19 years who applied for CHIP benefits or whose parent or guardian applied for CHIP benefits on the individual's behalf.

(3) "Benefits" means the services an enrollee is eligible for as outlined in this subchapter. All benefits with the exception of dental and eyeglass services, are provided to an enrollee through the insurer.

(4) "Benefit year" means the period from October 1st through September 30th of a calendar year. If an individual is enrolled in CHIP after October 1st, the benefit year is the period from the date of enrollment through September 30th of the calendar year.

(5) "Children's health insurance plan (CHIP)" means the children's health insurance plan described in this subchapter and administered by the department under Title XXI of the Social Security Act.

(6) "Department" means the Montana department of public health and human services.

(7) "Earned income" means income received from employment, self-employment activity, profession, vocation or pastime and includes wages, salaries, tips, commissions, profits, farm or ranch income and honoraria.

(8) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

(a) serious jeopardy to the health of the enrollee or the enrollee's unborn child;

(b) serious impairment of bodily function; or

(c) serious dysfunction of any bodily organ or part.

(9) "Enrollee" means an individual who is eligible to receive CHIP benefits as determined by the department under this subchapter and is enrolled with an insurer. An individual is not an enrollee while on a waiting list or pending issuance of a hearing decision or during any period a hearing officer determines the individual was not eligible for CHIP benefits.

(10) "Eyeglasses" means corrective lens and/or frames prescribed by an ophthalmologist or by an optometrist to aid and improve vision.

(11) "Family" means a group of individuals who are residing together as a single economic unit. Members of the economic unit are considered to live together even though a member may reside temporarily in a residential treatment setting. For purposes of this subchapter, a minor living alone shall be considered an economic unit.

(12) "Family span" means the 12 month period of eligibility beginning the first day of the month after an applicant qualifies for CHIP benefits and ending the last day of the 12th month. Although qualified for CHIP benefits, applicants placed on the waiting list may not be enrolled during the entire family span.

(13) "Federal poverty level (FPL)" means the poverty income guidelines for 2003 published in the Federal Register by the U.S. department of health and human services.

(14) "Guardian" means the custodial parent or a person granted legal guardianship of a child by court order, judgment or decree.

(15) "Incarcerated" means living in a facility which would be termed a public institution under medicaid regulations at 42 CFR 435.1009.

(16) "Income" or "family income" means the adjusted gross earned income as defined by federal tax law and regulations plus unearned income of the family as defined in this rule. Regular, continuing and intermittent sources of income will be annualized for purposes of determining the annual income level. Family income does not include:

(a) earned income of individuals in the household who are under 19 years of age, unless they are of school age and are not attending school;

(b) money received from assets drawn down such as withdrawals from a savings account, an annuity or from the sale of a house or a car;

(c) gifts, loans, one-time insurance payments, or compensation for an injury;

(d) per capita income to enrolled members of Native American tribes;

(e) earned income which is excluded and dependent care expenses which are deducted from income under the state medicaid poverty programs for children; or

(f) income excluded under federal medicaid regulations.

(17) "Institution for mental disease (IMD)" means a facility which would be termed an institute for mental disease under medicaid regulations at 42 CFR 435.1009.

(18) "Insurer" means an authorized insurer, health service corporation or health maintenance organization (HMO) with a valid certificate of authority issued by the Montana commissioner of insurance to transact business in the state of Montana.

(19) "Medicaid screening" means a determination by the department of an individual's potential eligibility to receive medicaid benefits applying the criteria set forth in ARM Title 37, chapter 82 and certain medicaid rules which disregard income.

(20) "Medically necessary" or "medically necessary covered services" means services and supplies which are necessary and appropriate for the diagnosis, prevention or treatment of physical or mental conditions as described in this subchapter and that are not provided only as a convenience.

(21) "Mid-level practitioner" is defined at ARM 37.86.202.

(22) "Montana resident" means a U.S. citizen or qualified alien who declares himself or herself to be living in the state of Montana, including a migrant or other seasonal worker.

(23) "Participating provider" means a health care professional or facility as defined at 33-36-103(19), MCA.

(24) "Premium" means the amount of money the department pays monthly to an insurer for the provision of benefits for each enrollee. The premium is paid whether or not the enrollee received covered benefits during the month for which the premium is intended. All benefits outlined in this subchapter, except eyeglass and dental benefits, are covered through payment of this premium.

(25) "Primary care provider" means a participating health care professional designated by the insurer to supervise, coordinate or provide initial care or continuing care to a CHIP enrollee and who may be required by the insurer to initiate a referral for specialty care and to maintain supervision of health care services to the CHIP enrollee.

(26) "Qualified alien" means a person residing legally in the United States, as defined by federal immigration laws and regulations and in ARM 37.78.220.

(27) "State employee" means a person, including the CHIP applicant, employed on a permanent basis by the state of Montana.

(28) "Unearned income" means income that is not defined as earned under this subchapter and includes interest, dividends, distributions from trusts or estates, social security benefits, veteran's benefits or payments, workers' compensation and unemployment compensation benefits. Unearned income does not include income excluded under federal medicaid regulations.

(29) "Waiting list" means a list of applicants who have been determined eligible for CHIP but who are not enrolled because funds are not available to pay their health care premiums. (History: Sec. 53-4-1009, MCA; IMP, Sec. 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 1027, Eff. 2/13/04.)

Subchapter 2

Eligibility

37.79.201 ELIGIBILITY (1) An applicant may be eligible for covered services under CHIP if:

(a) the applicant is under 19 years of age;

(b) the applicant's social security number is provided. Benefits will not be denied or delayed to an otherwise eligible applicant pending issuance of his or her social security number;

(c) the family of which the applicant is a member has annual family income, without regard to other family resources, at or below 150% of the 2003 federal poverty level (FPL);

(d) the applicant is a Montana resident;

(e) the applicant is a U.S. citizen or qualified alien as defined under federal statute;

(f) the applicant is not incarcerated;

(g) the applicant is not an inpatient in an institution for mental disease on the date of application or reapplication;

(h) the applicant does not have or has not had creditable health insurance coverage as defined in 42 USC 300gg(c) during the three months prior to applying for CHIP. This three month waiting period shall not apply if the parent or guardian providing the insurance:

(i) dies;

(ii) is fired or laid off;

(iii) can no longer work due to a disability;

(iv) has a lapse in insurance coverage due to new employment; or

(v) has an employer who does not offer dependent coverage.

(i) the applicant or the applicant's parent is not eligible for health insurance coverage under the state of Montana employee's health insurance plan; and

(j) the applicant is not eligible or potentially eligible for medicaid coverage as determined by the department.

(2) Income information for all family members must be included on the signed and dated application.

(a) Income information will be used by the department to project the family's income.

(b) The family's debts, medical expenses or other financial circumstances will not be taken into consideration when determining family income.

(3) An applicant whose CHIP enrollment ended because his or her parent was activated into military service and who was insured through tri-care, which is the insurance available to active duty and retired military families during the parent's military activation period, is not subject to the three month waiting period for previous creditable health insurance and will be enrolled in CHIP if he or she continues to be eligible for CHIP. Upon notification that the parent was deactivated and the applicant loses tri-care coverage, the applicant may be re-enrolled:

(a) the month after CHIP is notified, if the family has an open family span; or

(b) the month after a completed application is received and the applicant re-qualifies for CHIP benefits, if the family does not have an open family span.

(4) Applicants eligible to receive services from the Indian health services (IHS) program administered by the United States department of health and human services are eligible for CHIP if they meet the criteria specified in this subchapter.

(5) Applicants who are losing medicaid coverage or who were denied medicaid for a reason other than the family withdrew their application or failed to comply with medicaid requirements will be referred to CHIP via an electronic report. CHIP eligibility will be determined and applicants will be enrolled in CHIP or placed on the CHIP waiting list.

(a) Applicants will be mailed a form to authorize the use and disclosure of health information that will include questions about the family's health insurance and whether health insurance is available to the family.

(6) Applicants and their parents or guardians must comply with the procedures specified by the insurer or the department or both as necessary to obtain or access benefits.

(7) CHIP benefits do not start until the applicant is enrolled with the insurer even though the applicant may have been determined eligible for CHIP prior to the date of enrollment.

(8) CHIP eligibility is redetermined within one year after the initial eligibility period, and annually thereafter. A renewal application must be completed, signed, dated and returned by a specified date for purposes of eligibility redetermination. Prior eligibility for CHIP does not guarantee continued eligibility nor enrollment with an insurer.

(9) CHIP eligibility and benefits are not an entitlement. If funding is insufficient, the department may reduce enrollment numbers or reduce eligibility to a lower percentage of the federal poverty level to limit the number of individuals who are eligible to participate.

(10) A determination of CHIP eligibility will be completed within 20 working days after receipt of a complete application. (History: Sec. 53-4-1004 and 53-4-1009, MCA; IMP, Sec. 53-4-1003 and 53-4-1004, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 1027, Eff. 2/13/04.)

37.79.202 NON-QUALIFYING APPLICANTS (1) Applicants determined by the department to be eligible for medicaid through a medicaid determination process are not eligible to receive CHIP benefits.

(2) Applicants determined by the department to be potentially eligible for medicaid during the CHIP eligibility determination process will be referred to their local office of public assistance for a determination of medicaid eligibility.

(3) Applicants who are themselves eligible or who have a parent who is eligible for state employee insurance benefits are not eligible for CHIP.

(4) Applicants who apply for CHIP benefits while they are patients in an institution for mental disease (IMD) shall not be enrolled in CHIP until they are discharged from the IMD. A CHIP enrollee who becomes a patient in an IMD shall not lose CHIP benefits solely because the enrollee is a patient in an IMD.

(5) Applicants who are incarcerated cannot be enrolled in CHIP.

(6) Applicants who are not eligible for CHIP benefits because their family income exceeds the CHIP income guideline for the family size will be referred to other health care programs for children, as appropriate. (History: Sec. 53-4-1004 and 53-4-1009, MCA; IMP, Sec. 53-4-1003 and 53-4-1004, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04.)

Rules 03 through 05 reserved

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37.79.206 ELIGIBILITY REDETERMINATION, NOTICE OF CHANGES

(1) Eligibility determinations shall be effective for a period of 12 months unless one or more of the following changes occurs:

(a) the enrollee moves from the state of Montana;

(b) the enrollee moves, does not notify CHIP of the new address and CHIP is unable to locate the enrollee;

(c) the enrollee is found to have other creditable health coverage;

(d) the enrollee becomes an inmate of a public institution;

(e) the enrollee attains the age of 19 years;

(f) the enrollee or the enrollee’s parent becomes eligible for state employee benefits before the expiration of the 12 month eligibility period;

(g) the enrollee dies; or

(h) the enrollee becomes eligible for medicaid.

(2) Parents or guardians must give notice within 30 days when the family moves or another change specified in (1) occurs.

(3) A CHIP renewal application must be completed and CHIP eligibility redetermined every 12 months. If the renewal application is not returned before CHIP enrollment is scheduled to end, benefits will terminate. A new application may be completed at a later date but the applicant may be placed on the waiting list. (History: Sec. 53-4-1009, MCA; IMP, Sec. 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04.)

37.79.207 TERMINATION OF ELIGIBILITY AND GUARDIAN LIABILITY (1) CHIP eligibility terminates immediately upon:

(a) death of the enrollee; or

(b) incarceration of the enrollee.

(2) CHIP eligibility terminates at the end of the month:

(a) the enrollee attains the age of 19 years;

(b) the parent or guardian or enrollee becomes eligible for state employee insurance benefits;

(c) the department becomes aware that the enrollee is a beneficiary of other creditable health insurance;

(d) the enrollee is determined eligible for medicaid;

(e) upon voluntary disenrollment of the CHIP enrollee;

(f) the enrollee moves out of Montana;

(g) the department becomes aware that the applicant has moved without providing a new address and CHIP is unable to locate the applicant; or

(h) when a completed renewal application has not been received by the department.

(3) Termination of eligibility, based on insufficient funding at the department may not be effective earlier than the end of the month notice of termination is given to the enrollee or the enrollee's parent or guardian.

(4) A parent or guardian is liable to the department and the department may collect from the parent or guardian the amount of actual premiums or payments or both to providers for any benefits furnished to the enrollee because of an intentional misrepresentation or a failure to give notice of changes as required by this subchapter. (History: Sec. 53-4-1009, MCA; IMP, Sec. 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04.)

37.79.208 PROVISIONAL BENEFITS, DETERMINATION OF ELIGIBILITY AND APPLICATIONS FOR CHIP (1) Provisional CHIP benefits may be extended to enrollees who would otherwise lose health care coverage while awaiting a medicaid determination. Provisional coverage may be extended to enrollees who:

(a) submit a completed CHIP renewal application before their CHIP benefits are scheduled to end;

(b) have been determined potentially eligible for medicaid coverage; and

(c) are awaiting a medicaid eligibility determination.

(2) A determination of CHIP eligibility will be completed within 20 working days after receipt of a complete application.

(3) Applications for applicants who appear to be medicaid eligible will be forwarded to the appropriate county office of public assistance for a medicaid eligibility determination within 20 working days after receipt of a complete application.

(a) Applicants who are denied medicaid coverage for failure to comply with medicaid eligibility requirements:

(i) are not eligible for CHIP benefits; and

(ii) will not have their application referred to other health care resources.

(b) CHIP applications will be processed for those applicants who subsequently provide information which would preclude them from medicaid eligibility. (History: Sec. 53-4-1009, MCA; IMP, Sec. 53-4-1004, MCA; NEW, 2004 MAR p. 330, Eff. 2/13/04.)

37.79.209 ELIGIBILITY VERIFICATION REVIEWS (1) To verify the eligibility determination, a random sample of families will be required to participate in an eligibility verification review and provide documentation to verify the income information as stated on their applications.

(a) A family will have 14 days from the date of the written request by the department to submit the required income documentation.

(b) If a family does not provide documentation, CHIP-eligible applicants will be taken off the CHIP waiting list or disenrolled, as appropriate.

(c) A family who provides documentation after 14 days will have the application reprocessed as if it is a new application.

(2) If an enrollee's family income exceeds CHIP income guidelines, the enrollment will be terminated or if applicable, the applicant's name will be removed from the waiting list.

(3) For purposes of this rule, necessary income documentation may include one or more of the following:

(a) pay stubs or other pay statements;

(b) employee's W-2 forms;

(c) state or federal income tax returns;

(d) union records;

(e) check copies;

(f) self-employment bookkeeping records;

(g) sales and expenditure records;

(h) employer's wage or payroll records;

(i) award notices or award letters;

(j) correspondence from an employer specifying a benefit;

(k) records of any government payor; or

(l) other appropriate, persuasive documentation may be accepted at the discretion of the department. (History: Sec. 53-4-1009, MCA; IMP, Sec. 53-4-1004, MCA; NEW, 2004 MAR p. 330, Eff. 2/13/04.)

Subchapter 3

Benefits

37.79.301 COVERED BENEFITS (1) An insurer must provide medically necessary benefits including inpatient and outpatient hospital, physician, advanced practice registered nursing, prescription drugs, laboratory and radiology, mental health, chemical dependency, vision, audiology and medical dental benefits as provided in this subchapter unless specific limitations to benefit coverage are noted.

(2) Eyeglasses and dental benefits are paid by the department as specified in ARM 37.79.322 and 37.79.326.

(3) Emergency services, including urgent care and emergency room screening to determine if a medical emergency exists, shall be available 24 hours per day, seven days per week. In emergency situations, no pre-authorization is required to provide necessary medical care and enrollees may seek care from nonparticipating providers. The insurer may, however, require prior authorization for any needed follow-up care. (History: Sec. 53-4-1009, MCA; IMP, Sec. 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04.)

37.79.302 COVERAGE LIMITATIONS (1) The lifetime maximum benefit coverage is one million dollars per enrollee per enrollee insurer.

(2) Pre-existing conditions of each enrollee are covered as of the effective date of enrollment if the condition would be otherwise covered except in the following conditions:

(a) an enrollee, hospitalized prior to the date of enrollment, who remains in the hospital on the effective date of initial CHIP coverage shall not be covered for inpatient benefits for such hospitalization only. Upon discharge, the enrollee shall become eligible for benefits for any subsequent inpatient hospitalizations. This exclusion shall not apply to enrollees who are renewing their CHIP enrollment.

(3) The insurer shall provide covered benefits to an enrollee who is receiving inpatient hospital benefits up to and including the 11th day after the effective date of losing CHIP benefits.

(4) A newborn of a CHIP enrollee shall have all medically necessary benefits covered by the insurer for 31 days after the newborn's date of live birth. Coverage for the newborn shall begin the day of live birth, without regard to whether the newborn is hospitalized on the date of coverage. (History: Sec. 53-4-1009, MCA; IMP, Sec. 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04.)

37.79.303 BENEFITS NOT COVERED (1) In addition to any exclusions noted elsewhere in these rules, the following services are not covered benefits:

(a) experimental services or services generally regarded by the medical profession as unacceptable treatment;

(b) custodial care;

(c) personal comfort, hygiene and convenience items which are not primarily medical in nature;

(d) whirlpools;

(e) organ and tissue transplants;

(f) treatment for obesity;

(g) acupuncture;

(h) biofeedback;

(i) chiropractic services;

(j) cosmetic surgery;

(k) radial keratotomy;

(l) private duty nursing;

(m) treatment for which other coverage such as workers' compensation is responsible;

(n) routine foot care;

(o) ambulance or other medical transportation;

(p) abortions which are not performed to save the life of the mother or to terminate a pregnancy which is the result of an act of rape or incest;

(q) in vitro fertilization, gamete or zygote intra fallopian transfer, artificial insemination, reversal of voluntary sterilization, transsexual surgery or fertility enhancing treatment beyond diagnosis;

(r) acupressure;

(s) contraceptives, for the purpose of birth control;

(t) temporomandibular joint (TMJ) treatment;

(u) hypnosis;

(v) durable medical equipment;

(w) mental health therapy when the enrollee is not present; and

(x) any treatment which is not medically necessary. (History: Sec. 53-4-1009, MCA; IMP, Sec. 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04.)

Rules 04 through 06 reserved

37.79.307 INPATIENT HOSPITAL BENEFITS (1) Inpatient hospital benefits are provided, including but not limited to:

(a) a semi-private room;

(b) intensive and coronary care units;

(c) general nursing;

(d) drugs;

(e) oxygen;

(f) blood transfusions;

(g) laboratory;

(h) imaging services;

(i) physical, speech, occupational, heat and inhalation therapy;

(j) operating, recovery, birthing and delivery rooms;

(k) routine and intensive nursery care for newborns; and

(l) other medically necessary benefits and prescribed supplies for treatment of injury or illness.

(2) Coverage of postpartum care for at least 48 hours for vaginal delivery and 96 hours for caesarean section is guaranteed. Any decision to shorten the length of inpatient stay to less than these stated amounts shall be made by the attending provider and the mother. (History: Sec. 53-4-1009, MCA; IMP, Sec. 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00.)

37.79.308 OUTPATIENT HOSPITAL BENEFITS (1) Outpatient hospital benefits provided include all benefits described in the inpatient hospital rule, ARM 37.79.307, which are provided on an outpatient basis in a hospital or ambulatory surgical center, and also include:

(a) chemotherapy;

(b) emergency room benefits for surgery, pain, accident or medical emergency; and

(c) other services for diagnostic or outpatient treatment of a medical condition, accident or illness. (History: Sec. 53-4-1009, MCA; IMP, Sec. 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04.)

37.79.309 PHYSICIAN AND ADVANCED PRACTICE REGISTERED NURSE BENEFITS, LIMITATIONS AND EXCLUSIONS (1) The services of physicians and advanced practice registered nurses are covered benefits.

(2) Prenatal care is covered as described for other medical conditions in these rules.

(3) Well baby, well child, and immunization services as recommended by the American academy of pediatrics and the advisory committee on immunizations practices are covered.

(4) Routine physicals for sports, employment or as required by a governmental authority are covered.

(5) Anesthesia services rendered by a physician-anesthesiologist (other than the attending physician or assistant) or by a nurse anesthetist are covered providing that surgical and/or hospital services are also covered.

(6) Hypnosis, local anesthesia, unless included in the procedure charge, and consultations prior to surgery are not covered.

(7) Surgical benefits are covered as described in ARM 37.79.307, 37.79.308 and this rule. In addition, professional services rendered by a physician, surgeon or doctor of dental surgery for treatment of a fractured jaw or other accidental injury to sound natural teeth and gums are covered.

(8) Medical or surgical treatment to reverse surgically induced infertility, fertility enhancing procedures beyond diagnosis and sex change operations are excluded.

(9) Medically appropriate second opinions which may include major diagnoses or courses of treatment are a covered benefit. (History: Sec. 53-4-1009, MCA; IMP, Sec. 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04.)

Rules 10 and 11 reserved

37.79.312 PRESCRIPTION DRUG BENEFITS (1) Prescription drug benefits include drugs prescribed by a health care provider acting within the scope of his practice.

(2) Chemotherapy drugs approved for use in humans by the U.S. food and drug administration, vaccines, prenatal vitamins, and drugs needed after an organ or tissue transplant are covered.

(3) Prescribed diabetic supplies including insulin, test tape, syringes, needles and lancets are covered as a prescription drug.

(4) Food supplements and vitamins are not covered except prenatal vitamins and medical foods for treatment of inborn errors of metabolism as provided in 33-22-131, MCA. The need for a prescription to obtain food supplements or vitamins shall not affect the application of this rule.

(5) The insurer shall use the medicaid formulary if it chooses to employ a formulary. (History: Sec. 53-4-1009, MCA; IMP, Sec. 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00.)

37.79.313 LABORATORY AND RADIOLOGY BENEFITS

(1) Laboratory and radiological benefits include imaging and laboratory services for diagnostic or therapeutic purposes due to accident, illness or medical condition that are not described elsewhere in these rules.

(2) X-ray, radium or radioactive isotope therapy are covered. (History: Sec. 53-4-1009, MCA; IMP, Sec. 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00.)

Rules 14 and 15 reserved

37.79.316 MENTAL HEALTH BENEFITS (1) Mental health benefits include:

(a) inpatient services furnished by public or private licensed and qualified practioners in a hospital, including a state-operated mental hospital, a residential service or a partial hospitalization program; and

(b) outpatient services furnished by public or private licensed and qualified practitioners in a community based setting or in a mental hospital.

(2) Mental health benefits are limited to:

(a) 21 days of inpatient mental health care per benefit year;

(b) partial hospitalization benefits which are exchanged for inpatient days at a rate of two partial treatment days for one inpatient day; or

(c) 20 outpatient visits per year which can be furnished in community based settings or in a mental hospital.

(3) Mental health benefits will not be limited for enrollees with the following disorders:

(a) schizophrenia;

(b) schizoaffective disorder;

(c) bipolar disorder;

(d) major depression;

(e) panic disorder;

(f) obsessive-compulsive disorder; and

(g) autism.

(4) Mental health benefits shall be provided at least to the extent required by state law. (History: Sec. 53-4-1009, MCA; IMP, Sec. 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 1027, Eff. 2/13/04.)

37.79.317 CHEMICAL DEPENDENCY BENEFITS (1) Inpatient chemical dependency treatment benefits include treatment in an inpatient hospital or residential chemical dependency treatment center.

(2) The combined benefit for inpatient and outpatient treatment for alcoholism and drug addiction, excluding costs for medical detoxification, is subject to a maximum benefit of $6,000 in a 12-month period. Inpatient benefits are limited to a lifetime maximum benefit of $12,000. After the inpatient lifetime maximum benefit has been met, the annual benefit may be reduced to $2,000.

(3) Chemical dependency benefits shall be provided at least to the extent required by state law. (History: Sec. 53-4-1009, MCA; IMP, Sec. 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04.)

Rules 18 through 20 reserved

37.79.321 VISION BENEFITS (1) Vision benefits and medical eye care include:

(a) services for the medical treatment of diseases or injury to the eye;

(b) vision exams; and

(c) a dispensing fee for eyeglasses which are ordered from the department's contractor and provided by a licensed physician, opthamologist, optometrist or optician working within the scope of the profession. (History: Sec. 53-4-1009, MCA; IMP, Sec. 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04.)

37.79.322 EYEGLASS BENEFITS (1) Eyeglasses shall be paid by the department through a single volume purchase contract.

(2) An enrollee is limited to one pair of eyeglasses per 365 day period unless additional pairs are necessary due to any of the following circumstances:

(a) cataract surgery;

(b) .50 diopter change in correction in sphere;

(c) .75 diopter change in cylinder;

(d) .5 prism diopter change in vertical prism;

(e) .50 diopter change in the near reading power;

(f) a minimum of a 5 degree change in axis of any cylinder less than or equal to 3.00 diopters;

(g) a minimum of 3 degree change in axis of any cylinder greater than 3.00 diopters;

(h) any 1 prism diopter or more change in lateral prism; or

(i) the inability of the enrollee to wear bifocals because of a diagnosed medical condition.

(3) When the enrollee meets one or more of the conditions in (2)(a) through (2)(i), the enrollee may be allowed two pairs of single vision eyeglasses per 365 day period.

(4) Contact lenses are not a covered benefit. (History: Sec. 53-4-1009, MCA; IMP, Sec. 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 1027, Eff. 2/13/04.)

Rules 23 and 24 reserved

37.79.325 AUDIOLOGY BENEFITS (1) Audiological benefits include hearing exams for assessment and diagnosis.

(2) Newborn hearing screens in a hospital or outpatient setting are covered.

(3) Hearing aides are not a covered benefit. (History: Sec. 53-4-1009, MCA; IMP, Sec. 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00.)

37.79.326 DENTAL BENEFITS (1) The maximum dental benefits paid will be 85% of the billed services received up to $350 paid per benefit year for each enrollee. For example, $412 in services received would result in $350 paid.

(a) Providers may not balance bill the enrollee, parent or guardian for the remaining 15% of the billed charges.

(b) Providers may bill the enrollee, parent or guardian for services received in excess of $412 per benefit year.

(2) Providers must bill for services using the procedure codes and modifiers set forth, and according to the definitions contained in the American Dental Association Manual of Current Dental Terminology Third Edition (CDT-3).

(3) The following procedures are not a benefit of the CHIP dental program:

(a) D5900 through D5999 maxillofacial prosthetics;

(b) D6000 through D6199 implant services;

(c) D7610 through D7780 treatment of fractures;

(d) D7940 through D7999 other repair procedures; and

(e) D8000 through D8999 orthodontics.

(4) Providers must comply with all applicable state and federal statutes, rules and regulations, including the United States Code governing CHIP and all applicable Montana statutes and rules governing licensure and certification.

(5) Providers must also comply with the requirements of ARM Title 37, chapter 85, subchapters 4 and 5 to the extent those provisions are not inconsistent with this subchapter.

(6) For purposes of applying the provisions of any medicaid rule as required by this subchapter, references in the medicaid rule to "medicaid" or the "Montana medicaid program" or similar references shall be deemed to apply to CHIP as the context permits. (History: Sec. 53-4-1009, MCA; IMP, Sec. 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04.)

Subchapter 4 reserved

Subchapter 5

Enrollment Provisions

37.79.501 COST SHARING PROVISIONS (1) Except as provided in (2) and (3), the parent or guardian of each CHIP enrollee whose family income is greater than 100% of the federal poverty level must pay to the provider of service the following copayments not to exceed the cost of service:

(a) $25 per admission for inpatient hospital services including hospitalization for physical, mental and substance abuse reasons;

(b) $5 per visit for emergency room services;

(c) $5 per visit for outpatient hospital visits including outpatient treatment for physical, mental and substance abuse reasons;

(d) $3 per visit for physician, APRN, PA, optometrist, audiologist, mental health professional, substance abuse counselor or other covered health care provider services;

(e) $3 per prescription or refill of an outpatient generic drug; and

(f) $5 per prescription or refill for an outpatient brand-name drug;

(2) No copayment shall apply to:

(a) well baby or well child care, including age-appropriate immunizations;

(b) outpatient hospital visits for x-ray and laboratory services;

(c) dental, pathology, radiology or anesthesiology services; or

(d) families with at least one enrollee who is a Native American Indian or Native Alaskan.

(3) The total copayment for each family shall not exceed $215 per family per benefit year. (History: Sec. 53-4-1009, MCA; IMP, Sec. 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04.)

Rule 02 reserved

37.79.503 ENROLLMENT WITH AN INSURER (1) Applicants eligible for CHIP must enroll with an insurer under contract with the department.

(2) When more than one insurer contracts with the department to provide services in the area in which a family lives, the family may request enrollment with a particular insurer.

(a) If the family fails to choose an insurer, the department may assign an insurer.

(3) All eligible CHIP family members must enroll with the same insurer.

(4) An insurer must accept without restriction eligible applicants in the order in which they are received for enrollment until the insurer's maximum enrollment, if any, under the contract is reached.

(5) The enrollment date will always be the first day of the enrollment month. An applicant will be enrolled the later of:

(a) the month after the applicant is determined eligible; or

(b) the month funding is sufficient to enroll the applicant from the waiting list.

(6) The insurer must:

(a) provide each enrollee with a handbook of information about CHIP including a summary of benefits; and

(b) issue an appropriate identification card to each enrollee. (History: Sec. 53-4-1009, MCA; IMP, Sec. 53-4-1003 and 53-4-1007, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04.)

37.79.504 RIGHT TO CHOOSE PRIMARY CARE PROVIDER (1) An applicant, parent or guardian must have the opportunity to choose a primary care provider to the extent possible and medically appropriate from the providers available at the time of enrollment. The insurer may assign an enrollee to a primary care provider if an enrollee, parent or guardian fails to choose one after being notified to do so. The assignment must be appropriate to the enrollee's age, gender and residence. The enrollee may change primary care providers once annually without good cause as defined in Montana insurance law and rules. (History: Sec. 53-4-1009, MCA; IMP, Sec. 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04.)

37.79.505 DISENROLLMENT WITH AN INSURER

(1) Participation in CHIP is voluntary and an enrollee may withdraw from the program at any time.

(2) An enrollee, parent or guardian may request, without good cause, disenrollment from one insurer and enrollment with another insurer annually.

(3) An insurer, based on good cause, may request that the department disenroll an enrollee. The request with the reason for the request must be in writing.

(a) CHIP benefits may be terminated for good cause if the enrollee, parent or guardian has violated rules adopted by the Montana commissioner of insurance for enrollment with an insurer.

(b) Good cause shall be defined as provided in Montana insurance law and rules and does not include an adverse change in health status.

(4) Disenrollment takes effect, at the earliest, the first day of the month after the department receives the request for disenrollment, but no later than the first day of the second calendar month after the request for disenrollment is received. The enrollee remains enrolled with the insurer and the insurer is responsible for benefits covered under the contract until the effective date of disenrollment, which is always the first day of a month.

(5) The department will disenroll an enrollee from a particular insurer if:

(a) the contract between the department and the insurer is terminated;

(b) the enrollee permanently moves outside the geographic area served by the insurer and:

(i) no other insurer can provide care through participating providers; and

(ii) the enrollee, parent or guardian does not agree to travel to the nearest participating provider for medical care except in the instances noted in ARM 37.79.605; or

(c) the enrollee becomes ineligible for CHIP. (History: Sec. 53-4-1009, MCA; IMP, Sec. 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04.)

Subchapter 6

Services and Provider Requirements

37.79.601 CONTRACTS FOR BENEFITS (1) The department may enter into a contract with an insurer with a certificate of authority issued by the Montana commissioner of insurance to provide any of the benefits specified in these rules.

(2) An insurer entering into a contract with the department for the delivery of benefits assumes the risk that the costs of performance may exceed the consideration available through the premium.

(3) An insurer must provide the department with documented assurances to show that the insurer is not likely to become insolvent. This requirement may be satisfied by documenting compliance with rules adopted by the commissioner of insurance.

(4) An insurer may not in any manner hold an enrollee, parent or guardian responsible for the debts of the insurer.

(5) The department may contract with one or more insurers in an enrollment area.

(6) The department may contract with a vendor to purchase eyeglasses under a volume purchase contract.

(7) The department may contract with individual dentists to provide dental benefits as specified in ARM 37.79.326. (History: Sec. 53-4-1009, MCA; IMP, Sec. 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04.)

37.79.602 PROVISION OF BENEFITS (1) An insurer may impose the following requirements in the provision of benefits:

(a) the use of certain types of providers to the extent allowed by law;

(b) preauthorization for benefits other than emergency services;

(c) directing an enrollee to the appropriate level of care for receipt of covered benefits; and

(d) denial of payment to a provider for benefits provided to an enrollee if the participation requirements in this rule are not met by the enrollee or the enrollee's parent or guardian.

(2) An enrollee must use an insurer's participating providers unless:

(a) the insurer authorizes a nonparticipating provider to provide a service; or

(b) the enrollee receives emergency services or emergency room screen.

(3) An insurer and its participating providers must provide covered benefits as listed in this subchapter to enrollees in the same manner as those benefits are provided to non-CHIP members in the insurance plan.

(4) An insurer may at its discretion offer benefits beyond the scope of CHIP benefits defined in this subchapter. (History: Sec. 53-4-1009, MCA; IMP, Sec. 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04.)

Rules 03 and 04 reserved

37.79.605 PARTICIPATING PROVIDERS (1) An insurer, unless otherwise provided in this rule or Montana law, may select the providers of medical services it deems necessary to meet its contractual obligations with the department.

(2) An insurer must maintain an adequate network of participating providers to serve enrollees. The insurer must notify the department when providers are deleted from the network.

(3) An insurer may establish its own enrollment and reimbursement criteria for participating providers.

(4) The insurer must offer to federally qualified health centers (FQHCs), rural health clinics (RHCs), Title X family planning providers, Indian health services providers, tribal health providers, urban Indian centers, migrant health centers and county public health departments terms and conditions that are at least as favorable as those offered to other contract providers, if these entities substantially meet the same access and credentialing criteria as other contract providers and only for geographic areas jointly served by the entities and the insurer.

(5) Upon written notice by the department, the insurer must exclude from providing benefits to CHIP enrollees a provider who is currently suspended or terminated by the medicaid or the medicare program in any state.

(6) Participating providers shall be licensed or certified in Montana or in the case of out-of-state providers, in the state in which they practice.

(7) Physicians, advanced practice registered nurses and physician assistants shall either have admitting privileges to at least one general or critical shortage area hospital or shall have a mechanism in place to ensure hospitalization when appropriate.

(8) An insurer may set notification and claim filing time limitations relating to the provision of care by nonparticipating providers. Failure to give notice or file claims within those time limitations, however, does not invalidate any claim if it can be shown not to have been reasonably possible to give such notice and that notice was in fact given as soon as was reasonably possible.

(9) A provider has no right to an administrative hearing with the department when the insurer has denied payment for a service provided to an enrollee.

(10) A provider, in providing benefits under contract with an insurer, is not subject to any requirements or rights provided in this rule.

(11) An insurer may not prohibit a participating provider from:

(a) discussing a treatment option with an enrollee, parent or guardian; or

(b) advocating on behalf of an enrollee within the utilization review or grievance processes established by the insurer. (History: Sec. 53-4-1009, MCA; IMP, Sec. 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 1027, Eff. 2/13/04.)

37.79.606 REIMBURSEMENT OF INSURERS (1) In consideration for all services rendered by an insurer under a contract with the department, the insurer will receive a payment each month for each enrollee. This payment is the premium. Unless otherwise provided in this rule, the premium represents the total obligation of the department with respect to the costs of medical care and benefits provided to each enrollee under the contract. Payment of the premium is considered to be payment in full and the insurer may not bill the enrollee, parent or guardian, nor let its providers bill the enrollee, parent or guardian for any medical care provided beyond the cost-sharing provisions outlined in ARM 37.79.501.

(2) The insurer may retain any savings realized by the insurer from the expenditures for necessary health benefits by the enrolled population totaling less than the premium paid by the department. (History: Sec. 53-4-1009, MCA; IMP, Sec. 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04.)

37.79.607 UTILIZATION REVIEW AND QUALITY ASSURANCE

(1) The insurer shall have adequate staff and procedures to assure that health care provided to enrollees is medically necessary and appropriate.

(2) The insurer shall comply with and cooperate in any external quality review that may be implemented by the department or its designee. An external quality review may include participation in the design of the review, collection of data and making data available to the department or its designee. (History: Sec. 53-4-1009, MCA; IMP, Sec. 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04.)

Subchapter 7 reserved

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Subchapter 8

Hearing and Appeal Procedures

37.79.801 GRIEVANCE AND APPEAL PROCEDURES (1) An insurer must have a written procedure, approved in writing by the department before implementation, for resolution of grievances or complaints brought by enrollees or their parents or guardians either individually or as a class. In a situation requiring urgent care or emergency care, the department may require the insurer to expedite resolution of a grievance within a time line established by the department.

(2) Except when CHIP eligibility has been denied, an enrollee, parent or guardian must exhaust the insurer's grievance procedure before appeal of the matter may be made to the department.

(3) An applicant, parent or guardian aggrieved by a denial, suspension or termination of CHIP eligibility or an enrollee, parent or guardian aggrieved by a final grievance decision of an insurer, including but not limited to a reduction or denial of benefits, may request a fair hearing in accordance with ARM 37.5.304, 37.5.313, 37.5.322, 37.5.325, 37.5.328, 37.5.334 and 37.5.337. The provisions of ARM 37.5.305 do not apply to such hearings.

(4) If a written request for hearing is not received by the department within 90 days after the date a notice of adverse action is mailed by the department or a final grievance decision is mailed by an insurer, the hearing officer may deny a hearing as provided in ARM 37.5.313.

(5) A proposal for decision by the hearing officer is a final agency decision for purposes of 2-4-702, MCA and is subject to judicial review as provided in Title 2, chapter 4, part 7, MCA. (History: Sec. 53-4-1009, MCA; IMP, Sec. 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04.)